

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **62-017233**

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2038

FILED MAY 1 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS 6090 Maple Ave.	
3. NAME OF DECEASED (Type or print) First Elmer Middle C. Last Schneider		4. DATE OF DEATH Month February Day 17 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/24/1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Market	
13a. FATHER'S NAME Curt Schneider		13b. MOTHER'S MAIDEN NAME Alma Scheiter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		17. INFORMANT Alma Schneider, Mt. Olive, Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO (b) with Pulmonary Edema. DUE TO (c) 416x		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour 12:15 a.m. P Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 12:15 P and last saw her him alive on 12-19-62 Death occurred at 12:15 P on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Nelene L. Taylor, Coroner	
22b. ADDRESS 1300 Clark Ave.		22c. DATE SIGNED 2-19-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-20-62	
23c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cemetery		23d. LOCATION (City, town, or county) Mt. Olive, Ill.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. FEB 19 1962	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert M. Murray
Robert M. Murray
Licensed Embalmer No. 3749

P. O. Address St. Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.